PRINTED: 05/04/2007

| | | & MEDICAID SERVICES | • | • | FORI | M APPROVEI D. 0938-0391 | |
|--------------------------|--|--|-----------------------|--|-------------------|--------------------------------------|--|
| STATEMENT | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (XC2) MUI A. BUILD | TIPLE CONSTRUCTION | (X3) DATE COMP | SURVEY . | |
| | | 09G12 4 | 8. WING | | 044 | 04/19/2007 | |
| NAME OF F | PROVIDER OR SUPPLIER | | s | TREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION). | ID PREFIX TAG | PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY) | OULD BE | (XS) COMPLETION DATE | |
| . W 000 | INITIAL COMMENT | \$ | W 00 | 0 | • | | |
| | 17, 2007 through A initiated using the fu random sample of f | vey was conducted from Aprilloril 19, 2007. The survey was indamental survey process. A our clients was selected from tion of eight male clients with disabilities. | , | | 2001 MAY 30 | OSPARTMI HEALTH ADMIN | |
| W 114 | observations at the programs. Also the and staff Interviews day programs, as w | | W 114 | 4 W114 | 30 D 2: 19 | CEIVED NI OF HEALIH REGULATION | |
| | | nakes an entry in a client's legibly, date it, and sign it. | | | | , | |
| | Based on observation verification, the facili consultation forms for the facility of the facil | not met as evidenced by: on, staff interview and record ty falled to date clients or one of the four clients in | , | This Standard will be as evidenced by: | , | | |
| • | the sample. (Client The finding includes | , | | Primary Care Physics be directed to dote all | an will | 5.16.07 ongoing | |
| | April 19, 2007, it was had reviewed the clic October 2, 2006. At recommended that the discontinuing one of medications (Zantac medical records refis Physician (PCP) affir | Client #1's medical record on a noted that the pharmacist ent's medication regimen on that time, the pharmacist he physician consider the client's gastrointestinal at the client's pastrointestinal at the Primary Care sed his initials on the received in a no date to reflect if | | Routine record reviews/auch be completed by medica to further ensure co with this standard. | , | | |
| BORATORY | | RVSUPPLIER REPRESENITATIVES SIGN | MITURE | TITLE DES. | | (X6) DATE | |
| | Manay Branch | | | DKS. | | E-14.07 | |

Any deficiency statement ending with an esterisk (*) denotes a deficiency whichtha institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days offlowing the date of survey whether or not a plan of correction is provided. For hursing homes, the above findings and plans of correction are disclosable 14 tays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program perticipation.

| CENT | ERS FOR MEDICARE | I AND HUMAN SERVICES & MEDICAID SERVICES | , , | | FOR | D: 05/04/2003 M APPROVED D. 0938-039 |
|---|--|--|----------------------|---|----------------------|--|
| STATEME AND PLAN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILD | TIPLE CONSTRUCTION ING | (X3) DATE | |
| · <u>.</u> | | 09G124 | B. WING | | 041 | dr maan |
| NAME OF | PROVIDER OR SUPPLIER | | 1 | TREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020 | <u> </u> | 19/2007 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY) | 1 N O BE | (X5) COMPLETION DATE |
| W 114 | Continued From page | | · W 114 | | | · |
| W 148 | to discontinuing the | ed the recommendations prior Zantac in April 2007. VUNICATION WITH S & | | WI48 | | |
| ### ### ### ### ### ### ### ### ### ## | parents or guardian changes in the clien | ify promptly the client's of any significant incidents, or t's condition including, but not ness, accident, death, abuse, ence. | 1 | | | |
| • | Based on interview a failed to notify paren | not met as evidented by: and record review, the facility ts or guardians of significant fac eight clients residing in #2, #3, #4 and #7) | | This Standard will be as emberced by: | e met | |
| | The finding includes: | | | | | 1 1 |
| | and investigations or approximately 9:00 A the facility failed to no | 's unusual incident reports Prebruary 20, 2007 at M, revealed evidence that Othy family members Bowing significant incidents | | OMEP will notify parents quardians of significan incidents, immediately OMEP will document no | and t otificat | S.30.07 ongoing |
| | bruise on Client #3's to the nurse on duty. | 2005, staff discovered a back and reported the bruise The nurse observed bruise 06 and did not report the he policy. | | in accordance to polland procedures. | icy | |
| - | b. On April 5, 2006, s "humps" on Client #4 | staff discovered fresh blood is left hand. | | Routine QA audits be completed to | will | |
| | c. On December 10, involved in a vehicle of the barber shop. | 2006, Client #7 was accident while returning from | , | Routine QA auduts be completed to further ensure compliance with etandard. | this | |
| | | | | | | ľ |

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/04/2007 CENTERS FOR MEDICARE & MEDICAID SERMCES FORM APPROVED OMB_NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER COMPLETED A. BUILDING 8 WING 09@124 04/19/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE · 1 D t WASHINGTON, DC 20020 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PRÉFIX TAG (X5) COMPLETION DATE PREFIX TAG DEFICIENCY W 148 Continued From page 2 W 148 d. The direct care staff reported that upon the Client #2's arrival to his day program on September 29, 2006 he appeared to be asleep. The nurse reported that the client "felt dold" upon examination/assessment. The local Emergency Medical Service (EMS) was called and the client was taken to the local emergency room. W 149 483.420(d)(1) STAFF TREATMENT OF W149 W 149 CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. This Standard will be met as evidenced by: This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to establish and/or implement policies that ensure the health and safety for eight of the eight client reside in the facility. (Clients #1, #2, #3, #4) #5, #6, #7 and #8) 5-30-07 The finding includes: Reference response ongoing The facility failed to ensure the implementation of to W153. their incident management policy. Interview was conducted with the Qualified Mental Retardation Professional (QMRP) on April 17, 2007 at 9:45 AM to ascertain if the facility had a written incident management policy. The QMRP presented the policy which was reviewed on April-17, 2007. The policy failed to address injuries of unknown origin. (See W153) W 153 W153 483.420(d)(2) STAFF TREATMENT OF ·W 153

The facility must ensure that all allegations of mistreatment, neglect or abuse, as well as

CLIENTS

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 05/04/2007 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION NO PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: COMPLETED A BUILDING B. WING 09G124 04/19/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1290 CONGRESS STREET, SE IDI WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X4) ID PROVIDER'S PLAN OF GORRECTION PRÉFIX (XS) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) W 153 Continued From page 3 W 153 W153, continued., injuries of unknown source, are reported immediately to the administrator or to other officials in accordance with State law through established procedures. This Standard will be met as evidenced by This STANDARD is not met as evidenced by: Based on interview, review of unusual incidents. and review of medical records, the facility failed to ensure that all unusual incidents including injuries of unknown origin were reported immediately to the administrator and other officials according to district law (22 DCMR, Chapter 35, Settion 3519.10) for three of the four clients in the sample. (Clients #2, #3 and #4) The finding includes: additional training on On April 17, 2007 at 9:45 AM, review of the facility's incident reports revealed the following injuries of unknown origin that were not reported incident management procedures. 5-30-07 immediately to the administrator and to the ongoing government officials as required. Also, reference response to W148. a. The direct care staff reported that upon the Client #2's arrival to his day program on September 29, 2006 he appeared to be asleep. to the administrator and The nurse reported that the client "felt cold" upon examination/assessment. The local Emergency Medical Service (EMS) was called and the client was taken to the local emergency room. to the government officials b. On April 5, 2006, staff discovered fresh blood as required. "humps" on Client #4's left hand. c. On December 12, 2006, staff discovered a bruise on Client #3's back and reported the bruise to the nurse on duty. The nurse observed bruise on December 10, 2006 and did not report the

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 05/04/2007 FORM APPROVED OMB NO. 0938-0391

| STATEMEN AND PLAN | OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A. BUILDI | TIPLE CONSTRUCTION NG | (X3) DATE | (X3) DATE SURVEY COMPLETED | |
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| | | 096124 | B. WING | | DAI | 19/2007 | |
| וסו | PROVIDER OR SUPPLIER | | | REET ADDRESS, CITY, STATE, ZIP 0 1230 CONGRESS STREET, SE WASHINGTON, DC. 20020 | | 13/200/ | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF () (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY | ON SHOULD BE LE APPROPRIATE | (X5) COMPLETION DATE | |
| ™ 153 | | | W 153 | | | | |
| W 154 | wound was cleaned 483.420(d)(3) STAF CLIENTS | With soap and water. FTREATMENT OF | W 154 | W154) | | | |
| | violations are thorou | | | This Standard W | ill be | | |
| | Based on interview : failed to investigate | inot met as evidented by; and record review, the facility injuries of unknown origin for the sample. (Clients #1 and | | This Standard w met as evidence | d by: | 5.30.07 engana | |
| • | The findings include | | , | _ 0 | n-cn 1 -m | , - , | |
| | 17, 2007 at 9:45 AM | al incident reports on April , revealed the following of unknown origin that had nd/or investigated: | · | Reference resp W153 and W/ | 18. | - | |
| | bruise on Client #3's to the nurse on duty. | , 2006, staff discovered a back and reported lithe bruise The nurse observed bruise 06 and did not report the the policy. | | | | | |
| W 159 | b. On May 9, 2006, a on the upper lip and wound was cleaned v 483.430(a) QUALIFII RETARDATION PRO | ED MENTAL | W 159 | (W159) | , | | |
| | Each client's active to integrated, coordinate | eatment program must be ed and monitored by a | | | | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

| DEPAR | RTMENT OF HEALTH | AND HUMAN SERVICES & MEDICAID SERMICES | | • | FÓRM | 05/04/2007 APPROVED |
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| STATEME | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) ML | JILTIPLE CONSTRUCTION DING | OMB NO. (X3) DATE SI COMPLE | 0938-039 <u>1</u> JRVEY TED |
| | | 09G124 | B. WIN | g | 04/41 | 0/000 7 . |
| NAME OF | PROVIDER OR SUPPLIER | - | - | STREET ADDRESS, CITY, STATE, ZIP CODE | | 9/2007 |
| 101 | | | | 1230 CONGRESS STREET, SE WASHINGTON, DC 20020 | | |
| (X4) ID PREFIX TAG | · (Each Deficiency | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BE IDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOCK CROSS-REFERENCED TO THE AP | (Outrae i | (XS) COMPLETION DATE |
| W 159 | 1 | ge 5 ardation professional. | W 11 | | - | |
| | Based on observation review, the facility's Professional (QMRF | not met as evidenced by: on, staff interview and record Qualified Mental Retardation) failed, to adequately of coordinate each client's | | This Standard will met as evidenced | ll be | · |
| | with the direct care s Practical Nurse (LPN approximately 5:00 F for evening medicatic client should not be r wheelchair, at this fir Therapy assessment revealed a recomme provided opportunitie alternative seating (I. chair) every two hour 483.440(c)(3)(iii) IND The comprehensive f Identify the client's sp behavioral managem This STANDARD is r Based on observation verification, the facility comprehensive function | D7 during evening #3 remained in his DPM until 7:45 PM. Interview staff and the Licensed DPM until 7:45 PM. Interview staff and the Licensed DPM undicated that it was time ons or dinner time and the epositioned out of his ne. Review of an Physical dated July 5, 2008 however indation for the client to be to be repositioned in an e., bean bag or redilner a during waking hours. IVIDUAL PROGRAM PLAN curtional assessment must edific developmental and ent needs. | W 214 | additional training all staff on report will purchase ad positioning equipments of the positioning staff/maxwill continue to and provide oversifurther ensure with standard. W214 This Standard will be evidenced by: | accer duhonal upment nagers monitor ght to compliance | S. 18:07 ongoing |

| CENTERS FOR MEDICARE & ME STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PI | ROVIDER/SUPPLIER/CLIA ENT/PICATION NUMBER; | (X2) MULT | IPLE CONSTRUCTION | | 0938-0391 |
|--|--|---------------------|---|--|----------------------------|
| | | A. BUILDIN | | (X3) DATE SI COMPLE | |
| | 09G124 | B. WING_ | | . 04/1 | 9/2007 |
| NAME OF PROVIDER OR SUPPLIER | | 1 | REET ADDRESS, CITY, STATE, ZIP GODE 1230 CONGRESS STREET, SE NASHINGTON, DC 20020 | | |
| (X4) ID SUMMARY STATEMEN PREFIX (EACH DEFICIENCY MUST' I TAG REGULATORY OR LSC IDEN | BE PRECEDED BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEPICIENCY) | HOULD BE | (X5) COMPLETION DATE |
| W 214 Continued From page 6 included in the sample. (4) The finding includes: | Client #3) | W 214 | 772 | | ' |
| Review of Client #3's physical 2007 revealed that the client and administered Ativan 2 combative and non-composite medical appointments. In Qualified Mental Retardat (QMRP) and the Licensed confirmed that the Ativan address non-compliant be client during medical appointment at the Ativan address non-compliant be client during medical appointment at the provide behaviors exhibited were addressed by a least restrictions exhibited were addressed by a least restrictions to a least interventions to stoward independence. This STANDARD is not in Based on interviews and infailed to ensure that there instructions for implementations for implement | ent had been prescribed 2 mg to address liant behaviors during ferview with the ion Professional 1 Practical Nuise (LPN) was administered to phaviors exhibited by the bintments. Interview e client's record evidence that the assessed and/or ictive technique. IAL PROGRAM PLAN an must describe upport the individual net as evidended by: acord review, the facility were clear, written ing clients physical of the four clients in the eximately 7:00 PM, red performing lower interview with the | W 240 | medical some prescribed medical somethingues with the Psychechniques with the extraction techniques with the determine other strated and medical somethingues can be utilized address chieves non-compliant will be reviewed to a method committee of a comment all of the extention of the committee of a comment all of the evidenced by: W240 This Standard will evidenced by: | edications in interest to be eassessed to any sed to at the house of attendance of will stions | 5.31.07 ongoing |

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| | | AND HUMAN SERVICES & MEDICAID SERVICES | | | FORM | APPROVED . 0938-0391 |
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| TATEMEN | T OF DEFICIENCIES OF CORRECTION | (21) PROVIDER/SUPPLIBRICLIA IDENTIFICATION NUMBER: | (X2)·MU Å BUILI | LTIPLE CONSTRUCTION DING | (X3) DATE S COMPLI | |
| | • | 09G124 | B. WING | · | 04/1 | 9/200 7 |
| NAME OF F | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP GO 1230 CONGRESS STREET, SE WASHINGTON, DC 20020 | • | ' |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CO | A SHOULD BE | (XE) COMPLETION DATE |
| W 240 | Plan revealed that a which stated, "giver client] will tolerate to flexion and abducted dorsiflexion) 10/10 analysis sheet indicated the exercise. Review of 2007 through April 2 care staff were door direct care staff fails exercises completed Qualified Mental Responded to the name of further indicated the modifications to the staff. | of the Individual Program he client has an objective in physical assistance, [the awer extremity exertises (hip an, knee flexion and ankle trials Review of the task ated that the direct care staff is number of trials for each if the data sheet from January 2007 revealed that the direct comenting on however the ed to identify the specific d. Further interview with the standation Professional nat the data sheet should each exercise. The QMRP at the would make data sheet and re-leservice | W 24 | amep will complete training for all dis staff. Dines will complete program impleme and documentate and documentate follow-up (i.e. dis action, training, of as needed to for ensure ongoing co with this standa | ne to monitori entertioni on. de recessory suplinary judance) wither impliance | 5.18.07 020000 |
| vv 24/ | The individual progropportunities for clies self-management. This STANDARD is Based on observation review, the facility folient was provided choice during their solients in the sample The finding includes Observations on April 10:00 AM, direct care Client #1 pudding as | s not met as evidenced by: on, staff interview, and records alled to ensure that each an opportunity to have a mack time for one of the four a. (Client #1) | W 24 | This Standard met as evident as evident for staff outlining providing opportuning and choices. | ices only | Ì |

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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| AND PLAN | IT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING | | (X3) DATE SURVEY COMPLETED |
| ∵ ₹ | , | 09G124 | B. WING_ | | 04/46/2407 |
| NAME OF F | PROVIDER OR SUPPLIER | | 4 ' | REET ADDRESS, CITY, STATE, ZIP 1220 CONGRESS STREET, SE WASHINGTON, DC 20020 | 04/19/2007 CODE |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | PREFIX TAG | PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCY | IDN SHOULD BE COMPLETION THE APPROPRIATE DATE |
| W 249 | Continued From particle client enjoys the the environmental in there was a variety of the refrigerator. At in the client given the officent given the officent the variety of the telent given the officent the variety of the telent given the officent the variety of the telent must reconstructed a client's each client must reconstruct the telent ground th | snack he received. During aspection on April 19, 2007, of snacks in the paritry and time during snacktime was opportunity to select a snack pod choices. ERAM IMPLEMENTATION disciplinary team has individual programplan, elve a continuous active consisting of needed evices in sufficient flumber opport the achievement of the in the individual program. not met as evidended by: not met as evidend | W 247 | DEFICIENCY | il be met ide additional active rums e ongoing overlight ck and led to wevernent |
| | 2007, the direct care Client #3 and then wi with the direct care st alent had limited rang Review of the IPP, de | dons from April 17 - 19, staff was observed feeding wing his mouth. Interview aff on indicated that the se of motion in his arms. sted July 31, 2006, revealed which stated, "given hand | ÷ | review program in weekly monthly Also reteren response to redarding position | nplementation, basis. |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIPLE CONSTRUCTION A BUILDING | | | | (X9) DATE SURVEY COMPLETED | | |
|--|---|---|--------------------|------|---|-------------------------------|---------|----------------------------|
| | | 096124 | B. WIN | G | | - | 04/1 | 9/2007 |
| NAME OF F | PRÓVIDÉR ÓR SUPPLIÉR | | | 1230 | 7 ADDRESS, CITY, ST CONGRESS STREI SHINGTON, DC 2 | ET, SE | , | , |
| (X4) ID PREFIX TAG | (SACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY-FULL SCIDENTIFYING INFORMATION) | ID PREFD TAG | < | (EACH CORRECT CROSS-REFERENC | | OULD BE | (X5) COMPLETION DATE |
| W 249 | mouth on 80% of the six consecutive mo. There was no evide | ge 9 ce, [the client] will wipe his le trials recorded per month for nth by January 2007. Ince that Client #3 received eatment in accordance with | W2 | 49 | | | | |
| | 2. The facility failed participated in activ | to ensure that Client #1 e treatment programs in IPP as evidenced below; | , | - | | | | |
| • | April 17, 2007, staff IPP dated Septemb program goal to Impliving by (a) Given h [Client name] will he sow of the trials recover hand assistant | t and dinner observations on fed Client #1. Review of his er 13, 2006 revealed a prove his activities of daily and over hand assistance, old his cup during mealtime on corded; and (b) Given hand be, [Client name] will bring his during mealtime on 80% of | | | | | | |
| | the Qualified Mental (QMRP) on March 1 | s brought to the attention of Retardation Professional 9, 2007. He acknowledged w the IPP recommendations. | | | | | | |
| | 3. The facility falled Client #3 to be report the Interdisciplinary | to provide opportunities to sitioned as recommended by Tezm (IDT). | | - | | | , | , |
| | Client #3 remained (PM until 7:45 PM. In staff and the License April 18, 2007 et app indicated that it was | during evening observations, in his wheelchair from 4:10 iferview with the direct care and Practical Nurse (LPN) on proximately 5:00 PM, time for evening medications are client should not be | | | | | | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED IDENTIFICATION NUMBER: A. BUILDING B. WING 09G124 04/19/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE 101 WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (XII) COMPLETION: (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX PREFIX TAG TAG DATE **DEFICIENCY**) W 249 Continued From page 10 W 249 W249, continued in repositioned out of his wheelchair, at this time. a ampp will modify change programs as needed. Review of an Physical Therapy assessment dated July 5, 2006 however revealed a recommendation for the client to be provided opportunities to be repositioned in an alternative seating (i.e., bean bag or recliner chair); every two hours during waking hours. The QMRP confirmed the repositioning protocol for the client. 4. The facility failed to provide continuous active: treatment for Client #3 to use his assistive devices (hand cones). The facility failed to allow Client #3 to use his assistive devices as identified by the Interdisciplinary team. On April 17, 2007 at 8:00 AM, Client #31was observed with his left hand clinched closed. Interview with the direct care staff indicated that the client did not have much range of motion in his hands. The direct care staff informed the surveyor that the client no longer used the Swanson hand cones. Review of an W264 Occupational Therapy assessment dated May 26. 2006 revealed a recommendation for the client to This Standard will be met as evidenced by wear a left Swanson handcone for up to three hours, twice a day. It should be noted that the client had achieved the previous program objective (to wear the hand cones). # COMEP will review and There was no evidence that during the survey the 5.31.07 client used the assistive devices as discuss all medication paropas recommended. changes with Human W 264 483.440(f)(3)(iii) PROGRAM MONITORING & W 264 CHANGE Rughes Commutee, prior to use of more restrictive

The committee should review, monitor and make: suggestions to the facility about its practices and

techniques.

| | | H AND HUMAN SERVICES | • | | | D: 05/04/200 II APPROVE |
|--------------------------|---|---|---------------------|---|---|----------------------------|
| STATEMEN | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULT | TIPLE CONSTRUCTION | OMB NO (X3) DATE S COMPL | |
| <u> </u> | · | 09G124 | B. WING_ | | 04/ | 19/2007 |
| NAME OF F | PROVIDER OR SUPPLIER | | 1 | REET ADDRESS, CITY, STATE, ZIP COD 1230 CONGRESS STREET, SE WASHINGTON, DC 20020 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X5) COMPLETION DATE |
| W 264 | programs as they re restraints, time-out or noxious stimuli, of behavior, protection | age 11 elate to drug usage, iphysical rooms, application of painful control of inappropriate of client rights and funds, and the committee believes need | W 264 | - amed will follow recommendations by the committee | w made | 5,31,07 |
| | Based on observation record review, the far Human Rights Commendations to suggestions to the far programs as they relights and any other believes that could be | s not met as evidented by: ons, staff interviews and acility failed to implement amittee (HRC) oreview, monitor and make facility about its practices and elate to protection of client or areas that the committee be an infringement of the exof four clients in the sample | • | all information s the rights of the are documented available for re | une that supporting e chents and | 4 |
| | 2007 revealed that the mg prior to a medical the Qualified Mental (QMRP) revealed the a consent authorizing HRC minutes, did no reveiwed or approve | siphysician order on April 16, the client received Altivan 2 all appointment. Interview with Retardation Professional at the client's guardian signed by the sedation. Review of the of evidence that the HRC and the use of medication for evention to address the Client's | · | This Standard will met as evidenced Reference respon- W264, | 16 | 5.31.07 ongoing |
| . W 278 | that restrictive measure the HRC prior to its u | MT OF INAPPROPRIATE | W 278 | | | , |

| DEPAR | RTMENT OF HEALT | H AND HUMAN SERVICES E & MEDICAID SERVICES | | | | FOR | D: 05/04/2007 M APPROVED |
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| STATEME | NT OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (XZ) N | | TIPLE CONSTRUCTION | (X3) DATE | O. 0938-0391 SURVEY PLETED |
| • | | 09G124 | B. WII | NĠ_ | | ,, | 40000 |
| NAME OF | PROVIDER OR SUPPLIER | | <u>-</u> - }- | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE NASHINGTON, DC 20020 | <u>1</u> U4 | /19/2007 |
| (X4) ID PREFIX TAG | ' I (EACH DEFICIENC | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF | ix | PROVIDER'S PLAN OF GORRES (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | JULD BE | (XS) COMPLETION DATE |
| W 278 | Continued From pa | ige 12 | W 2 | 278 | | | |
| | inappropriate client the use of more re- client's record docu incorporating the use | vern the management of behavior must insure, prior to strictive techniques, that the iments that programs se of less intrusive or more have been tried systematically to be ineffective. | | | | - | |
| | Based on observation review, the facility for use of a more restricted documents to the same of the sa | s not met as evidented by: on, interview and repord ailed to ensure that prior to the ctive technique, the client's that the use of more positive to be ineffective for one of four e. (Client #3) | | | | | |
| .] | 2007 revealed that the and aministered Attachmedical appointment Qualified Mental Resident Mental Resident during medical with staff and review however, falled to probe addressed by a leas 483,450(b)(3) MGM CLIENT BEHAVIOR | siphysician order on April 18, the client had been prescribed an 2 mg to address compilant behaviors during its. Interview with the tardation Professional ensed Practical Nurse (LPN) tivan was administated to ant behaviors exhibited by the lappointments. Interview of the client's record ovide evidence that the were assessed and/or trestrictive technique. | 'W 28 | | W288_ | , | |
| | lechniques to maria behavior must never | ge inappropriate client be used as a substitute for | • | | , | |]. |

| DEPA | RTMENT OF HEALTH | AND HUMAN SERVICES | | r · | FOR | D: 05/04/200 M APPROVE |
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| STATEME | NT OF DEFICIENCIES I DF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUL A BUILD | TIPLE CONSTRUCTION NG | OMB NO. 0938-03: (XS) DATE SURVEY COMPLETED | |
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| NAME OF | PROVIDER OR SUPPLIER | | .1 | REET ADDRESS, CITY, STATE, ZIP (1230 CONGRESS STREET, SE WASHINGTON, DC 20020 | | 19/2007 |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CONTROL CO | ON SHOULD BE IE APPROPRIATE | COMPLETION DATE |
| W 288 | Continued From page an active treatment | | W 288 | W 220) Similar | | |
| S. | Based on observation review, the facility fator manage inappropused as a substitute | not met as evidenced by: on, staff interview and record lied to ensure that techniques riate client behavior were not for the active treatment he four clients in the sample. | | This Standard in met as evidence Reference resp. W214. | | 5,31.97 ongaing |
| W 322 | assessment or devel plan for Client's non- medical appointment restrictive measures. 483.460(a)(3) PHYS | n (IDT) had instituted an oped a behavioral support compliance behaviors during its prior to the use of [See W214] ICIAN SERVICES | W 322 | W322 | <u>.</u> | |
| | review, the facility fail | not met as evidenced by: n, interview and record ed to ensure general and to of the four clients included #1 and #3) | · | This Standard us met as evidence | sell be al by, | |
| | The findings include: 1. During the review and April 19, 2007, it was pharmacist reviewed a regimen on October 2 | of Client #1's medital record | | | | |

PRINTED: 05/04/2007

FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OME NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY COMPLETED (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING B: WING D9G124 04/19/2007 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1230 CONGRESS STREET. SE IDI WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION) COMPLETION (X4) ID PREFIX PREFIX TAG DEFICIENCY) W 322 Continued From page 14 W 322 W322 consider discontinuing one of the clients · Nursing staff will review out recommendations, gastrointestinal medications (Zantac). Further review of the medical record revealed triat the and document follow-up Primary Care Physician (PCP) did not address the pharmacist recommendation until April 2, 2007, when the medication was discontinued. actions taken. RN will discuss findings 2. On May 16, 2006, Client #1 was evaluated by will primary can physician. All identified concerns the Audiologist. A complete evaluation could not 5.31.07 be performed. The Audiologist recommended that the client be sedated for the next visit. A will be addressed. ongoing nursing note dated February 27, 2007, indicated that the primary care physician was contacted to a Documentation pertaining approve the recommendation for sedation made to pruduo logical appt by the Audiologist. The PCP indicated that there and recommended medications was no need for the sedation. Further review of changes will also be the record failed to evidence any alternative methods developed or implemented to ensure reviewed, that Client #1 completed his audiology evaluation: & RN/medical staff will continue to On March 17, 2007 during evening review chent services observations. Client #3 remained in his wheelchair from 4:10 PM until 7:45 PM, Interview reasumendations; and with the direct care staff and the Licensed provide additional training Practical Nurse (LPN) on April 18, 2007 at approximately 5:00 PM Indicated that it was time as needed to ensure for evening medications or dinner time and the general and preventive client should not be repositioned out of his case is provided at all wheelchair, at this time. Review of a Physical Therapy assessment dated July 5, 2008 however times. revealed a recommendation for the client to be provided opportunities to be repositioned in an alternative seating (i.e., bean bag or redliner chair) every two hours during waking hours. 4. On April 17, 2007;at 8:00 AM, Clienti#3 was observed with his left hand clinched closed. Interview with the direct care staff indicated that

the client did not have much range of motion in

PRINTED: 05/04/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION DENTIFICATION NUMBER: A BUILDING 09G124 04/19/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION 10 (X4) ID (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX PRÉFIX REGULATORY OR LISC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) W 322 W 322 Continued From page 15 his hands. The direct care staff informed the. surveyor that the client no longer used the Swanson hand cones. Review of an Occupational Therapy assessment dated May 261 2006 revealed a recommendation for the client to wear a left Swanson handcone for up to three hours, twice a day. It should be noted that the client had achieved the previous program objective (to wear hand cones). W 325 482,460(a)(3)(iii) PHYSICIAN SERVICES W 325 The facility must provide or obtain annual physical examinations of each client that at a minimum includes routine screening laboratory examinations as determined necessary by the physician. This Standard will be This STANDARD is not met as evidenced by: Based on observations, staff interview and record met as evidenced by: verification, the facility failed to provide toutine laboratory testing as determined necessary by the physician for one of the four clients in the sample (Client #3) ■ All nurses will receive additional training on The finding includes: morritoring and trackund of laboratory studies. The facility failed to ensure that Client #3 obtained ongoing laboratory studies as prescribed by the * Nursing staff will continue to use the laboratory physician's orders. Observations during the breakfast and dinner on April 17, 2007 revealed that the client was being tracking form and coodinate fed by direct care staff. Interview with the direct testing as needed. care staff indicated that the client receives a low

confirmed the diet order.

fat, low cholesterol ground diet. Review of the

meal time protocol and current physician orders

· Laboratory testing will be completed for client#3.

PRINTED: 05/04/2007 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/GLIA (DENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED OCEN MULTIPLE CONSTRUCTIC N A. BUILDING B. WING 09G124 04/19/2007 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIPICODE · 1230 CONGRESS & TREET, SE IDI WASHINGTON, EC 20020 SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION (EACH COF RECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY W 325 Continued From page 16 W 325 W325, .. continued ... On April 17, 2007 at 6:10 PM, Client #3 was · Nursing staff will provide administered Zocor 89 mg. Interview with the necessary follow-up action medication nurse indicated that the client to ensure that all laboration received Zocor for the management of an results are received in a alevated cholesterollevels. Review of the client #3's physician orders dated March 2007 revealed timely manner an order for laboratory studies to include lipid panel, every six months. Record vertication a RN will conduct routine file indicated that the client received a Ibidiomilie on reviews to further ensure July 17, 2007. There was no evidence that the compliance with this standard. facility had any updated laboratory profiles. W 331 469.460(c) NURSING SERVICES W 331 The facility must provide clients with nursing services in accordance with their needs. This Standard will be met as evidenced by: This STANDARD is not met as evidenced by: Based on staff interview and record review the facility falled to ensure nursing services in accordance with the needs of two of four clients in the sample. (Clients #1 and #3) The findings include: 1) Reference response to W325. 1. The facility's nurse failed to ensure that Client 5-24.07 #3 obtained laboratory studies as prescribed by the physician's orders. [See W325] ongoing 2) Reference response 2. The facility's nurse failed to ensure that the

See W336]

health status was reviewed by the Registered Nurse (RN) on a quarterly or more frequent basis:

recommendations made by consultants were

addressed with the Primary Care Physidian in an timely manner to ensure Client #1 received a complete audiplogy examination as evidenced by

3. The facility's nurses falled to ensure

(3) Référènce response

Alternate methods will be reviewed and discussed.

to W264.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (KZ) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA COMPLETED DENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING B. WING 04/19/2007 09G124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1230 CONGRESS STREET, SE 101 WASHINGTON, DC 20020 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETION ID (X4) IÜ PREFIX (EACH DEPICIENCY MUST BE PRECEDED SYFULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG TAG DEFICIENCY W 331 W 331 Continued From page 17 the following: On May 16, 2006, Client #1 was evaluated by the Audiologist. A complete evaluation could not be performed. The Audiologist recommended that the client be sedated for his next visit. A nursing note dated February 27, 2007, (seven months later) indicated that the primary care physician was contacted for approval for sedation made by the audiologist. The PCP indicated that there was no need for the sedation. Further review of the record failed to evidence any alternative methods developed or implemented to ensure that Client #1 completed his audiology evaluation 483,450(c)(3)(iii) NURSING SERVICES W 336 V 336 W 336 Nursing services must include, for those clients certified as not needing a medical care plan, a review of their health status which must be on a quarterly or more frequent basis depending on client need. This Standard will be met This STANDARD is not met as evidended by: as evidenced by Based on interview and record review, the facility RN will ensure that review of 5 8.07 body systems is completed ongoing on a quarterly basis. failed to ensure that the health status was reviewed by the Registered Nurse (RN) on a quarterly or more frequent basis for one of the four clients in the sample. (Client #3) Routine file reviews will be conducted on regular basis. All identified concerns The finding includes: Review of Client #3's medical record on April 18, will be addressed in a timely 2007 reyealed a Nursing Quarterly Assessment dated April 17, 2007, however the review of the manner. body systems was incomplete.

TREATMENT

W 356

483.460(g)(2) COMPREHENSIVE DENITAL

W 356

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| | | AND HUMAN SERVICES | | | FORM | 05/04/2007 APPROVED 0938-0391 |
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| NAME OF P | ROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STATE, ZIP CO 1230 CONGRESS STREET, SE WASHINGTON, DC 20020 | ĎE | |
| (X4) (D PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | ID PREFD TAG | PROVIDER'S PLAN OF COR X (EACH CORRECTIVE ACTION | SHOULD BE | (XS) COMPLETION DATE |
| W 356 | The facility must en treatment services needed for relief of | ige 18 sure comprehensive dental that include dental care pain and infections, and maintenance of dental | W 3 | 356 (W35G) | | |
| | Based on observation review, the facility to | is not met as evidended by: ion, staff interview, and record- ailed to schedule timely dentali- ne of the four clients in the | | This Standard will as evidenced by: | be met | |
| ું W 43 6 | brown stains on his dental consultation revealed that the communication the dentist recommendation of the dentist receipt There was no evidental services had 483.470(g)(2) SPAThe facility must full and teach clients to choices about the inhearing and other devices. | Client #3 was observed with teeth. Record review of the dated April April 26, 2006 ient had "calculus deposits". nended scaling on the next of payment authorization. ence that the recommended I been performed. CE AND EQUIPMENT mish, maintain in good repair, a use and to make informed use of dentures, eyeglasses, communications alds, braces, | W 4 | RN will follow-up of dental consultate and follow actions will be do client #3 will be for cleaning as reliase W436 This Standard will as evidenced by: | rup currented. scheduled commended | 5.30.07 ongoing |
| , | Based on observat | s not met as evidenced by: ion, staff interview, and record illty falled to teach use 1 | | | | · |

DEPARTMENT OF HEALTH AND HUMAN SERVICES

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FORM APPROVED

| CENTER | S FOR MEDICARE | * MEDICAID SERVICES | _ | | OMB NO. | 0938-0391 | | | |
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| CENTERS FOR MEDICARE & MEDICAID SERVICES TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (XZ) MUL' | riple construction NG | | (XG) DATE SURVEY COMPLETED | | | | |
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| NAME OF PROVIDER OR SUPPLIER | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1230 CONGRESS STREET, SE WASHINGTON, DC 20020 | | | | | |
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| W 436 | assistive devices a interdisciplinary terminary terminary terminary terminary terminary terminary interview with his linterview with the client did not his hands. The discurveyor that the constructional Their 2006 revealed a rewear a left Swanson hours, twice a day client had achieve objective (to wear There was no evident was no evident was no evident had achieve objective that was no evident had achieve objective that was no evident had achieve the was no evident had achieve objective that had achieve that had achieve the had | as! a allow Client #3 to use his is identified by the sm. at 8:00 AM, Client #3 was left hand clinched closed. direct care staff indicated that ave much range of motion in rect care staff informed the slient no longer used the nes, Review of an apy assessment dated May 26 acommendation for the client to mandcone for up to three of the previous program. | | QMRP will consult Occupational The reparding the users for how All recommendate followed as americaning as indicated address programmed address pr | erapist se of ad cone. Ations will outlined. onal provide shaff ated. | 5.31.07 ongoing | | | |
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| Health Re | equiation Administra | stion | | | <u> </u> | | |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION UMBER; | | (X2) MULTIPLE CONSTRUCTION A BUILDING | | (X3) DATE SURVEY COMPLETED | | | |
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| 1 000 | INITIAL COMMEN | rs | - | : 000 | , | | |
| | 2007 through April initiated using the frandom sample of from a residential presidents with vary. The findings of the observations at the programs. Also the residents and staff home and day pros | was conducted from 19, 2007. The survey undamental survey properties was secondulation of eight making degrees of disabilities were based or residence and two definities were based interviews in both the grams, as well as a real incident reports. | y was rocess. A lected le lifes. n ay l on group view of | | | | |
| I 056 | Each GHMRP sharp preparation and se care of equipment, | RVICE / DINING ARE It train staff in the state rving of food, the cless and food preparation y conditions at all time | age, aning and in order | 6 056 | 1056 3502: Meal Serv | ces | , |
| | Based on observation review, the facility of GHMRP staff was preparation and secare of equipment. | met as evidenced by ion, interview and reprised to ensure that extrained in the storage rying of food, the clear and food preparation y conditions at all times. | ord ach aning and in order | | This Statute will has evidenced; omer/Home Manager coordinate and school staff for Food Har training as needed. Omer/Home Manager ensure that clocum | - will edule idlers | 6.8.0.7 ongoing |
| | 19, 2007, reflected provide adequate s | omnel and training file that the GHMRP fail staff trained in Food I | ed to landlers, | | ensuré that clocum is maintain on file review. | entatin for | ס |
| 1 058 | 3502.18 MEAL SE | RVICE / DINING ARE | EAS | 1 058 | | | • |
| Health Regul | ation Administration | 2 1 | | | TITLE | | (XB) DATE |

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| , 058 | nutritionist shall be ensure that each represcribed a modification according Habilitation Plan. This Statute is not Based on interview GHMRP failed to e | ige 1 Illation by a distition of conducted at least of conducted at least of conducted at least of conducted the conducted by the conducted conducted at least conducted by the conducted conducted at least conducted a | uarterly to property to proper | 1058 | This Statute will be evidenced by: | emet as | |
| | quarterly by the corresidents. (Residents.) The findings included. Review of Residented October 23, ground October 23, ground pureed meanitoring of the monitoring of the monitoring of the monitoring of the current physic nutritionist recommended the current physic nutritionist recommended of the current physic nutritionist recommended of the monitoring of the conducted quarterly included. | nsulting dictition for the cris #3 and #4) e: dent #4's nutrition as the current on the nutrition as the current on the nutrition as the current the nutrition as the current the curren | sessmenti ular hist low bread dieti I the las been | | Nutritionist will as all outstanding of reviews. amp will continue review and report quarterly status documentation inceded. | to | 5,31.07 Ungoing |
| I 161 | The manual shall t | ar needs. AND PROCEDURES be approved by the given and shall be reviet | pveming | 1161 | 1161 3507.2 Policies | :Pocedum | S . |

Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIEF/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING B. WING_ 04/19/2007 09G124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1230 CONGRESS STREET, SE IDI WASHINGTON, DC 20020 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BYFULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID COMPLETE PREFIX PREFIX TAG TAG DEFICIENCY) 161 Continued From page 2 1161 least annually. This Statute will be met as evidenced by: This Statute is not met as evidenced by: 6.1.07 Based on record review, the GHMRP governing orgoina body failed to review its policies and procedures Policy and Procedure manual was reviewed and approved annually. The finding includes: in October 2006. updated information will be filed in policy and Review of the policy and procedure manual on April 18, 2007 revealed an approval date of 2005 procedure manual for 1164 1 154 3507.4(b) POLICIES AND PROCEDURES review. The manual shall incorporate policies and procedures for at least the following: (b) Physical environment, which covers housekeeping, maintenance, household items 1164 and furnishings; 3507.4b This Statute is not met as evidenced by: This statute will be met Based on the review of records the Group Home osculdenced by: for Mentally Retarded Persons (GHMRP) failed to ensure that their Policies and Procedures' Manual 5.31.07 included a policy to address physical environment The kitchen and to include housekeeping, maintenance; and ONGOVINO physical environment policy will be filed in household items and furnishings. The finding includes: the policy and procedure Review of the personnel policies and procedures on April 18, 2007, revealed the GHMRP failed to have a policy on cleaning the kitchen and amra/Home Manager will physical environment. Conduct Curther training 1169 I 169 3507.4(g) POLICIES AND PROCEDURES in this area.

| Health Reg | <u>ulation Administra</u> | tion | | · · · · · · · · · · · · · · · · · · · | | | |
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (XZ) MULTIPLE CONSTRUCTION A, BUILDING B, WING | | (X3) DATE SURVEY COMPLETED | | | |
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| Ti pi (Si m br | rocedures for at le g) Resident life, wi nanagement of fun ehavlor managem | icorporate policies at least the following: nich covers clothing, ids, resident rights, d ent, services, parent ent, visitation, staff tre | liscípline, al and | 1169 | 1169. 3507.4 (g) Reference respor 5507.4 (b) | 150 ts | |
| T Rop 3 Ed ro T Bh | The finding included a ceview of the person April 18, 2007, to a conting an april 1509.2 PERSONNI is ach staff person secription, which control. This Statute is not assed on record reliave on file for reviall employees. The findings included a control is a control included a c | onnel policies and pithe GHMRP failed tolid washing clothes. EL POLICIES shall have a written judetalls each of his or duties and supervisionet as evidenced by the GHMRP failew current job description. | have a have a her major ory filled to iptions for | 1 202 | This Statute will met as evidenced whome Manager we ensure that all to descriptions are date. Home Manager will job descriptions monthly basis | ill lo up-to li check | 4.30.07 ongomicy |

| Health R | egulation Administra | tion | | | <u> </u> | · · · · · · · · · · · · · · · · · · · |
|---|---|---|--|----------------|---|---------------------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (XZ) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED 04/19/2007 | |
| NAME OF D | ROWIDER OR SUPPLIER | 050124 | STREET ADD | RESS, CITY, S | STATE, ZIP CODE | |
| 1DI | NOVIDER OR SUPPLIER | | 1230 CON | GRESS STI | REET, SE 8020 | |
| (X4) ID PREFIX TAG | /EACH DEFICIENCY | TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM | IFULL | PREFIX TAG | PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROPRIED TO THE | ULD BE COMPLETE DATE |
| l 204 l 204 | Confinued From pa | | | 1 204 1 204 | 1202, Continued., 1 3509.2 GMED will conduct | voutine |
| | job description to re beginning of emplo This Statute is not Based on record re have on file for revi all employees. The findings includ- Review of the person | met as evidenced by wiew, the GHMRP far ew current job describe: | r: liled to liptions for | | file audits and f feedback as needed further ensure con with this standar | novice |
| 1 206 | 2007, the GHMRP | failed to provide curi three direct care sta | entjob | 1 206 | 1200 3509.6 Personnel | Q lines |
| | annually thereafter, certification that a li performed and that | ior to employment at , shall provide a phys nealth inventory has t the employee 's he her to perform the re | Nician 's been aith status | | 3509.6 reisonia | TOTICAE 3 |
| | Based on review of ensure each emplo certification that ind been performed an | met as evidenced by records, the GHMR byee had a current place a health inversid documented the allow him/her to press. | P failed to. hysician's htory had mployee's | | This Statute will be as evidenced by: Human Resource departmensure that physician certifications are wall to request updated her | tated. |

| Health R | <u>equiation Administr</u> | ation | | | | | 7 |
|--------------------------|---|--|---|---------------------|---|--------------------------------|--------------------------|
| STATEMENT | ATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTII A. BUILDING B. WING | PLE CONSTRUCTION | (X3) DATE SUF COMPLET 04/19/ | ED | |
| | A | 09G124 | STREET AND | DRESS CITY S | STATE, ZIP CODE | 1 4-1 (0) | |
| NAME OF P | ROVIDER OR SUPPLIER | | 1230 CON | GRESS STE | REET, SE | | . ' |
| (X4) ID PREFIX TAG | (EACH DEFICIENC | ATEMENT OF DEFICIENCE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM | aifull | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY) | ioùid be i | (X5) COMPLETE DATE |
| 1 206 | the GHMRP failed certification for thr | sonnel files on April 1 to provide physician ee direct care staff (1 dion nurse (1997). | \$ | | recertifications 90 de prior to expiration a staff who fail to requested docume will be removed | submit entation from the | |
| 1 291 | Each record shall signed by each ind This Statute is no Based on record rensure each resid The finding include | be kept current, date dividual who makes a t met as evidenced b eview the GHMRP fa ents records were da | in entry. y: Jied to Ited. | | has been met. 1291 This statute will | tardard be wet | |
| 379 | each GHMRP shat Health, Health, Health Facunusual incident of interferes with a rearrangement, well places the resider be made by teleption followed up by writers. | eparting requirement ill notify the Departme citities Division of any or event which substates dent's health, well being or in any other tat risk. Such notification within ours or the next work | ent of active in the control of active in the | 1379 | Reference responsible of the Federal Report | encies | angaling |
| | Based on intervier failed to ensure the notified of unusual substantially interf | it met as evidenced by record review, the () is Department of Heal I limitents or events for each residents or the limitents or events of the limitents or exemptions or e | BHMRP Ith, was Inat Int's health | | Reference respons Federal Deficien Report W336 and | e to cy 3502.16 | • |

| Health R | equiation Administra | ation | | <u> </u> | | . - | |
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| STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER: | | (PC) MULTIPLE CONSTRUCTION A. BUILDING B. WING | | (X3) DATE SURVEY COMPLETED | | | |
| | | 09G124 | | _ | | 04/19 | 9/2007 |
| NAME OF PROVIDER OR SUPPLIER STREET A | | | | • | STATE, ZIP CODE | | |
| I D I 1230 CQN WASHING | | | TON, DC 2 | 0020 | · | , | |
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| 1 379 | Continued From pa work day. | ige 6 | | 1 379 | 3519.10 Emergenc | | |
| | The finding include Refer to Federal D W154 | s: eficiency Report W1 | 53 and | t. | Reference response federal Deficiency F W153 and W154. | to Report | |
| I 4 04 | 3520.6 PROFESSION SERVICES: GENERAL PROVISIONS | | | 1 404 | 140H 3520.6. | | |
| | as appropriate, ear with a resident in the professional instruct | service provider shall chrother person who is a CHMRP so that rections can be implemented by a programs at | ls working Nevent Ienlæd | | This Statute will as evidenced by: Reference response | be met | 5,30,07 |
| , | Based on staff inte Group Home for th (GHMRP) failed to | met as evidenced by rview and record review and record review Mentally Retarded ensure the implement made by the occupational Therapist. | lew, the Person ntation of | | Reference response Report WZ40. | 1 | |
| | The finding Include | es: encv Report - Citation | n W/240 | , | | | |
| 1 407 | | ION SERVICES: GE | , | 1 407 | 1407 3520.9 | | , |
| | service provider a | Il obtain from each pl written report at least ed during the preced | t quarterly | | This Statute will met as evidence | be d by; | |
| | Based on staff inte | t met as evidenced by rview and record revi tentally Retarded Pet | iew, the | | | | |
| | Market and a second | | | - | | | |

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FORM APPROVED

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Health Regulation Administration (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIAR/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND FLAN OF CORRECTION DENTIFICATION NUMBER: A BUILDING B. WING 04/19/2007 09G124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1230 CONGRESS STREET, SE IDI WASHINGTION, DC 20020 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL ID PREFIX (X4) KD (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETE PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) 1407 1407 Continued From page 7 1407 3520.9, continue ... (GHMRP), failed to provide evidence off a nursing and nutrition quarterly reports two of the four residents in the sample. (Residents #3 and #4) Reference response to 5,8,07 Report W336 and The finding includes: ongoing See Federal Deficiency Report - Citation W336 and 3502.16 3502.16 4421 I 421 3521.2 HABILITATION AND TRAINING 521.2 Habilitation/Training Each GHMRP shall provide habilitation and training to residents in the most normalizing This Statute will be met as evidenced by: environment and the least restrictive circumstances. This Statute is not met as evidenced by: Based on observation, staff interview and record: Reference response to Federal Deficiency report W 214 and W 298 review, the GHMRP failed to ensure habilitation 5,3007 and training for one of the four residents included ongoing In the sample. (Resident #3) The finding includes: See Federal Deficiency Report - Citations W214 and W288 1422 1422 3521.3 HABILITATION AND TRAINING 3521. 3 Habilitation/Training Each GHMRP shall provide habilitation; training and assistance to residents in accordance with This Statute will be met as evidenced by: the resident 's Individual Habilitation Plan. This Statute is not met as evidenced by: Based on observation, staff interview and records review, the GHMRP falled to ensure habilitation Reference response to Federal Deficiency Report and training was provided to its residents that would enable them to acquire and maintain life skills needed to cope more effectively with the W249.

Health Regulation Administration (XS) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA DOD MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A BUILDING IB: WING 04/19/2007 09/3124 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1230 CONGRESS STREET. SE WASHINGTON, DC 20020 IDI SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROMDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (XA) ID PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG 1:422 Continued From page 8 1422 demands of their environments and to achieve their optimum levels of physical, mental and social functioning. The finding includes: See Federal Deficiency Report - Citations W249 (430 1430 1430 3521.7(a) HABILITATION AND TRAINING 3521.70 Reference response to Federal Deficiency Report The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Eating and drinking (including table manners, W249. use of adaptive equipment, and use of appropriate utensils): This Statute is not met as evidenced by: The finding includes: **437** 3521.7(q) Habilitation/Training 3521.7(0) This Statute will be met See Federal Deficiency Report - Citations W249 (437 1437 3521.7(g) HABILITATION AND TRAINING 5118107 ongoing The habititation and training of residents by the GHMRP shall include, when appropriate, but not as evidenced by: be limited to, the following areas: Reference resportse to (g) Communication (including language development and usage, signing, use dif the Federal Deficiency Report Citations W249 telephone, letter writing, and availability and utilization of communications media, such as books, newspapers, magazines, radio, television telephone, and such specialized equipment as and W436. may be required); This Statute is not met as evidenced by: The finding includes:

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Health Regulation Administration

PRINTED: 05/03/2007 FORM APPROVED

(X3) DATE SURVEY COMPLETED YX2) MULTIPLE CONSTRUCTION (XII) PROVIDER/SUPPLIEN/CLIA STATEMENT OF DEFICIENCIES IDENTIFICATION NUMBER: AND FLAN OF CORRECTION A. BUILDING B. WING 04/19/2007 09G124 STREET AUDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1230 Congress Street, Se Washington, DC 20020 101 QC5) COMPLETÉ PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG 1:437 Continued From page 9 1437 See Federal Deficiency Report - Citations W249 1445 3521.7(0) HABILITATION AND TRAINING l 445 The habilitation and training of residents by the GHMRP shall include, when appropriate, but not be limited to, the following areas: (a) Motor and perceptual skills (including balance) posture, and gross and fine motor skills); This Statute is not met as evidenced by: The finding includes: See Federal Deficiency Report - Citations W436 This Statute will be met as evidenced by: 1 500 1500 3523.1 RESIDENT'S RIGHTS Each GHMRP residence director shall ensure that the rights of residents are observed and protected in accordance with D.C. Law 2-137, this chapter, and other applicable District and federali 5.3107 Reference response to Federal Deficiency laws. ongoling This Statute is not met as evidenced by: Report - Citation WI48 Based on record review, the GHMRP failed to ensure each residents rights for eight of the eight in the facility. (Residents #1, #2, #3, #4, #5, #6, W149, W153, W154, W156 #7, and #8) and W262. The finding includes See Federal Deficiency Report - Citation W148, W149, W153, W154, W156 and W262

Health Regulation Administration STATE FORM

| Health Regulation Administration TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | (X2) MULTIP A. BUILDING IB. WING | LE CONSTRUCTION | (X3) DATE SUR COMPLETE 04/19/ | D . | | |
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| NAME OF PI | ROVIDER OR SUPPLIER | 09G124 | 1230 COM | ress, city, s gress str fon, DC 20 | 020 | ······································ | |
| (X4) ID PREFIX TAG | | ATEMENT OF DEPICENCIE Y MUST BE PRECEDED BY LSG IDENTIFYING INFORM | FULL . | ID *PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | | COMPLETE DATE |
| | 2007 through Aprilinitizated using the random sample of from a residential residents with various at the findings of the observations at the programs. Also the resident and staff home and day properties and the facility's unused at the facility's unused at the facility's unused at the facility shall esservices of an unused of the person has offense listed in swithin the seven background other rules; or This Statute is the Based on Interview with the staff person in the staff pe | rwas conducted from 19, 2007. The survey fundamental survey if four residents was spopulation of eight mying degrees of disable survey were based as residence and two he findings were based interviews in both the ograms, as well as a liministrative records, and incident reports. SROUND CHECK moley or use the conficensed person if: as been convicted of section 4705.1 of these (7) years prior to a crick conducted pursuant of met as evidenced aw and record review have background charted in the conducted pursuant des: e house manager and religious and revealed to the conducted for the conducted pursuant des: | elected alle alle alle alle alle alle alle al | R 120 | Background Cher This Statute we met as evidence Human Resource for each potential prior to employ Human Resource will ensure that check is filed a available for rece | ill be ed by: e Department rund checks employee yment. Department background and made | |
| Health Re | failed to have cr | () assigned to this iminial background ch | etks. | | TILE | | (本) DA 単 ろり407 |

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